

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32491**

FILED OCT 27 1948

Registration District No. **187**

Primary Registration District No. **3014**

Registrar's No. **132**

1. PLACE OF DEATH:

(a) County **Dunklin**
(b) City or town **Kennett Independence**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Chester R. Pack Md Office
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Kennett, Mo**
(Specify whether)
In this community **Eight Months**
years, months or days

3. (a) PRINT FULL NAME **Donald Cean Trindle**

3. (b) If veteran, name war. No. **4**
3. (c) Social Security No. **4**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **U**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive **23** years 1948
7. Birth date of deceased **Jan** 23 1948
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 **19** hr. min.

9. Birthplace **Holcomb** **Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Un known**
13. Birthplace **un known**
(City, town or county) (State or foreign country)
14. Maiden name **Orvilla Trindle**
15. Birthplace **Angola** **Ind**
(City, town, or county) (State or foreign country)

16. (a) Informant **Orvilla Girten**
(b) Address **Holcomb, Mo-R 1**
17. (a) **Burial** (b) Date thereof **10-12-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sumach Cem**
18. (a) Signature of funeral director **Lentz Und Co**
(b) Address **Kennett, Mo**

19. (a) **10-13-1948** (b) **Carl H. Hunsford**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dunklin** **35**
(c) City or town **Holcomb, Mo-R 1**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **12**
year **1948** hour **7** minute **30** A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **107**
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence **10-12-1948**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury **3**
23. Signature **Walter Hunsford** **Coroner**
Address **Kennett, Mo** Date signed **10.12.48**

RECEIVED

District Health Office No. 2,

District File Number

Date Filed

1048-1347

10-18-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.